

MDR Tracking Number: M5-04-0230-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on September 19, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the medications Propoxyphene/Apap, Nexium, Neurontin, Metoclopramide, Ambien, and Cyclobenzaprine were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service 10-04-02 to 02-14-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3<sup>rd</sup> day of December 2003.

Georgina Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division  
GR/gr

November 26, 2003

Re: MDR #: M5-04-0230-01  
IRO Certificate No.: IRO 5055

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation.

**Clinical History:**

This female claimant sustained an abdominal strain while at work on \_\_\_. The records provided for review provide no mechanism of injury, and there is no attempt to connect the injury in \_\_\_ with the dates of service or medications in dispute.

**Disputed Services:**

Propoxyphene APAP, Ambien, cyclobenzaprine, Nexium, metoclopramide, and Neurontin prescribed during the period of 10/04/02 through 02/14/03.

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the medications in question were not medically necessary in this case.

**Rationale:**

The prescribed medications are not indicated for treatment of abdominal strain, particularly for an abdominal strain of over a year prior.

I am the Secretary and General Counsel of \_\_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,